Physician Notification and Parental Release of Confidential Information Form to the Exceptional Children Preschool Program

Directions: To be completed by the appropriate Primary Care Practice and/or Pediatrician (PCP) and sent to the appropriate Exceptional Children Preschool Program contact. Upon receipt, the school system will contact the family to set up a screen and/or referral meeting. The PCP is encouraged to provide the family with the contact name and number for the receiving school system.

Child Contact Information		
Child Name:	Date of Birth:	Gender: M F
Home Address Street:	City:	State: Zip:
Parent/Guardian Contact Information		
Parent/Guardian: _____ Street: _____ City: _____State: NC Zip: _____ Email:	Primary Language: _____ ○ Interpreter is needed due to English as a second language Ethnicity: _____	○ Interpreter needed due to deafness or a hearing impairment or other accommodation(s) due to disability (please specify):
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Physician Contact Information		
Physician Name:	Address:	Office Phone: Office Fax:
Reasons for Notification to Preschool Program (Check all that apply)		
Suspected delay in: ○ Motor skills ○ Cognitive skills ○ Social-Emotional skills ○ Communication skills ○ Behavioral skills ○ Speech-Language skills	○ Autism ○ **Screen tool (please attach) ○ ASQ ○ PED ○ MCHAT ○ ASQ-SE	○ Identified condition or diagnosis ○ Specific concerns _____ _____

If parent(s) has agreed to pursue services from the Exceptional Children Preschool Program and is prepared to provide parental consent for release of confidential information at this time, please complete the information below.

Specific records to be released to and/or received from this office (please check):	**Purpose of the disclosure:**	**Party to whom the disclosure will be made:**
○ **School system evaluation results** ○ **Vision screening/evaluation results** ○ **Hearing screening/evaluation results** ○ **Developmental screening results** ○ **Health screening results** ○ **Social Emotional/ Behavioral Health Screening results** ○ **Other**	▪ Notification for preschool exceptional children program services ▪ Educational/instructional planning	School system name: _____ School system in which the private school is located: _____

I give informed parental consent to disclose the confidential records listed above for the purpose(s) listed above, and to the part listed above:

Parent/Guardian Signature:_____ Date:_____
Unless otherwise revoked, this authorization expires one year from the date of signature

○ **I request a copy of the confidential records disclosed.**

****Notation:**
ASQ: Ages and Stages Questionnaire
ASQ-SE: Ages and Stages Questionnaire for Social and Emotional Development
MCHAT: Modified Checklist for Autism in Toddlers
PED: Parent's Evaluation of Developmental Status

To be completed by school system staff
Date received by school system:
Follow-up communication with family: